



STATE BOARD OF EQUALIZATION  
PROPERTY AND SPECIAL TAXES DEPARTMENT  
450 N STREET, SACRAMENTO, CALIFORNIA  
PO BOX 942879, SACRAMENTO, CALIFORNIA 94279-0064  
916 445-4982 • FAX 916 323-8765  
www.boe.ca.gov

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January 23, 2009

TO INTERESTED PARTIES:

SUPPLEMENTAL REPORTING REQUIREMENTS FOR NONPROFIT HOSPITALS

Beginning with the 2009 periodic claim review process, it is anticipated that a sampling of nonprofit hospitals eligible for the Welfare Exemption from property taxation will be required to provide supplemental information to the Board. This requirement is necessary to obtain reliable consistent information at the State level.

At a January 22, 2009 meeting, the Board heard discussions regarding the proposed form that will be used to gather the supplemental information from nonprofit hospitals. The Board directed staff to disseminate the proposed form to interested parties to solicit additional comments. Enclosed is a copy of proposed form BOE-268-H, *Supplemental Reporting Form – Organizational Clearance Certificate Holders, Nonprofit Hospital Organizations*.

An interested parties meeting will be held at the Board's headquarters in Sacramento, 450 N Street, on February 18, 2009, Room 122, 9:30 a.m. to noon, to discuss the form. Interested parties may submit comments in advance of the meeting to Ms. Sherrie Kinkle at [sherrie.kinkle@boe.ca.gov](mailto:sherrie.kinkle@boe.ca.gov) or sent to the above address. The agenda of the meeting will consist of soliciting information to perfect the content and format of the proposed form, including:

- Which, if any, questions are hospitals unable to produce a response to at this time? Why?
- Where, if anywhere, could the Board obtain the same data from another source that would be current and in a usable format?
- What could the Board do to make the reporting requirements easier for hospitals?

Following the interested parties meeting, staff will provide the Board with a final recommended form for adoption at the April 15, 2009 Board meeting in Sacramento. To hear the entire discussion of this issue at the January 22, 2009 Board meeting, you may access it at [http://www.boe.ca.gov/meetings/pdf/012109\\_PAN\\_January\\_Sacramento.pdf](http://www.boe.ca.gov/meetings/pdf/012109_PAN_January_Sacramento.pdf); click on Item P3, b.2., *Supplemental Reporting Requirements for Nonprofit Hospitals*. If you plan to attend the interested parties meeting on February 18, 2009, please advise Ms. Kinkle at 916-322-2921 or at [sherrie.kinkle@boe.ca.gov](mailto:sherrie.kinkle@boe.ca.gov).

Sincerely,

/s/ Dean R. Kinnee

Dean R. Kinnee, Chief  
County-Assessed Properties Division

DRK:sk  
Enclosure

**SUPPLEMENTAL REPORTING FORM –  
ORGANIZATIONAL CLEARANCE CERTIFICATE HOLDERS  
NONPROFIT HOSPITAL ORGANIZATIONS**


STATE OF CALIFORNIA  
BOARD OF EQUALIZATION  
[www.boe.ca.gov](http://www.boe.ca.gov)

This form is to be filed with BOE-278-OCC, Verification for Continued Eligibility of Organizational Clearance Certificate-Welfare and Veterans' Organization Exemption. The form must be completed and filed with the Board of Equalization, County-Assessed Properties Division, PO Box 942879, Sacramento, CA 94279-0064 by the due date indicated on BOE-278-OCC.

NAME OF ORGANIZATION \_\_\_\_\_

BOE OCC NUMBER \_\_\_\_\_

CORPORATE ID NUMBER \_\_\_\_\_

MAILING ADDRESS OF INSTITUTION (Street, City, Zip Code, County, State) \_\_\_\_\_

Accounting Period: ☐ Calendar Year ☐ Fiscal Year-ending \_\_\_\_\_

1. What were the organization's operating revenues (exclusive of gifts, endowments and grants-in-aid) for the following years?

2005	2006	2007	2008

2. What were the organization's operating expenses (includes depreciation based on cost of replacement and amortization of, and interest on indebtedness) for the following years?

2005	2006	2007	2008

3. Do the organization's operating revenues exceed operating expenses by 10% or more of those expenses, defined as *surplus revenues* for any of the following years? If yes, identify the amount. (Calculate the amount in 3(a) below)

2005	2006	2007	2008

(a) Calculation of Surplus Revenues

	2005	2006	2007	2008
Net Operating Income (Revenue minus expenses from above)				
10% of Operating Expense				
Variance (positive indicates surplus)				

4. What were the organization's operating and non-operating revenues and expenses?

Year	Total Operating Revenues	Operating Expenses	Non-Operating Revenues	Non-Operating Expenses	Net Operating Income
2005					
2006					
2007					
2008					

5. **Attach** to this form a copy of your certified/audited financial statements for the last four fiscal or calendar years. Also submit copies of IRS Form 990 for the last four years in electronic PDF format on CD.

6. If the organization had surplus revenues for any year, identified in question 3, did the organization use surplus revenues for debt retirement, plant or facility expansion, or reserve for operating contingencies?

☐ Yes ☐ No If yes, enter the total amount of such use for each of the following years:

Year	Debt Retirement	Plant or Facility Expansion	Reserve for Operating Contingencies
2005			
2006			
2007			
2008			

7. **Attach** to this form a description of major plant or facility expansion projects; identifying the project location, scope and timeline for completion.

8. **Attach** to this form a list of properties upon which your organization is claiming the welfare exemption. (*Identify address, county, Assessor's Parcel Number.*)

9. Does the organization have a charity care policy?

☐ Yes ☐ No If yes, provide a copy of the policy and identify the accounts (number and description) used to record such charity care and associated costs for the following years: (*Attach supplementary schedules, if necessary.*)

Account:					Total
2005					
2006					
2007					
2008					

10. Does the organization's hospital(s) provide medical care to Medicare, Medi-Cal or county indigent program recipients?

☐ Yes ☐ No If yes, provide the following information for each year: (*Attach supplementary schedules, if necessary.*)

- (a) Enter the total amount of contractual adjustments for the organization's hospital(s) in accordance with the Office of Statewide Health Planning and Development's Uniform System of accounts for hospitals.

Year	Medicare Recipients	Medi-Cal Recipients	County Subsidy Recipients	Total
2005				
2006				
2007				
2008				

- (b) Enter the total amount received by the organization's hospital(s) for care to such patients.

Year	Medicare Recipients	Medi-Cal Recipients	County Subsidy Recipients	Total
2005				
2006				
2007				
2008				

- (c) Does the organization maintain cost information for care provided to such patients?

☐ Yes ☐ No If yes, enter the total cost of care, according to the organization's cost accounting system.

Year	Medicare Recipients	Medi-Cal Recipients	County Subsidy Recipients	Total
2005				
2006				
2007				
2008				

11. Does the organization's hospital provide medical care for which discounted payments were received from patients for care (other than Medicare, Medi-Cal or county indigent program recipients)?

☐ Yes ☐ No If yes, provide the following information:

- (a) Enter the accounts (number and description) used to record such discounted payments and the associated amounts received for medical care for each year.

Account				Total
2005				
2006				
2007				
2008				

- (b) Enter the total charge amount prior to discount for each year.

Account				Total
2005				
2006				
2007				
2008				

- (c) Does the organization maintain cost information for care provided to such patients?

☐ Yes ☐ No If yes, enter the total cost of care, according to the organization's cost accounting system.

Account				Total
2005				
2006				
2007				
2008				

12. Did the organization's hospital(s) incur bad debt expense for medical care provided to uninsured patients or underinsured patients during any of the specified fiscal years?

☐ Yes ☐ No If yes, enter the hospital(s) total bad debt expense (based on cost accounting) for medical care to such patients?

Year	Uninsured Patients	Underinsured Patients	Total
2005			
2006			
2007			
2008			

13. Did your organization collect revenue from unpaid medical services through third-party collection services for any of the specified fiscal years?

☐ Yes ☐ No If yes, provide the following information:

- (a) Enter the number of delinquent accounts, debt amount and total collected and attach a list of debt collection firms used and contracts for such services.

Year	No. Delinquent Accounts	Debt Amount	Total Collected
2005			
2006			
2007			
2008			

- (b) Enter the number of liens made for delinquent accounts, the amount collected from liens, and the total amount expended to collect delinquent accounts.

Year	No. of Liens on Delinquent Accounts	Total Amount of Liens Collected	Total Amount Expended to Collect Such Debt
2005			
2006			
2007			
2008			

14. Did the organization's hospital(s) invest in, contribute assets to, or participate in any joint venture or similar arrangement with a non-profit or for-profit entity during any of the specified fiscal years?

☐ Yes ☐ No If yes, enter the total number of joint ventures and attach a description identifying the terms and entities involved.

2005	2006	2007	2008

15. Did the organization's hospital(s) provide funds, grants, or non-cash assistance including, but not limited to, supplies, materials, equipment, or medical services, to a public and/or non-related nonprofit tax exempt entity which operates health care facilities (hospitals, community clinics, etc) serving lower-income patients during any of the specified fiscal years?

☐ Yes ☐ No If yes, enter the total contribution amount, according to the hospital's cost accounting system and attach a description identifying the entities involved and what was contributed.

2005	2006	2007	2008

16. Attach to this form an organizational chart that identifies all legal entities related to and/or affiliated with the nonprofit organization receiving the welfare exemption from property taxation under Revenue and Taxation Code section 214. List the full names of the entities and complete street addresses.

17. Did your organization own and operate one or more outpatient clinics (clinics providing psychiatric services to children and/or multispecialty clinics described in Health & Safety Code § 1206, subd.(I)), which receive the welfare exemption from property taxation under Revenue and Taxation Code sections 214 for any of the specified fiscal years?

☐ Yes ☐ No If yes, enter the total number of outpatient clinics providing services and attach a list of clinics, including the clinic's full name, complete street address and type of clinic:

2005	2006	2007	2008

18. Enter the total compensation for the three most highly-compensated executives of the hospital organization for each of the following years. Attach a separate schedule that identifies the amounts of each of the 3 components that are included on the organization's annual Form 990, *Return of Organization Exempt From Income Tax*.

NAME			
2005			
2006			
2007			
2008			

NAME OF PERSON TO CONTACT FOR ADDITIONAL INFORMATION *(Please Print)*

TITLE

E-MAIL ADDRESS

TELEPHONE NUMBER

(      )

### CERTIFICATION

*I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing and all information contained herein, including any accompanying statements or documents, is true, correct, and complete to the best of my knowledge and belief.*

NAME OF CLAIMANT *(Please Print)*

TITLE

DATE

SIGNATURE OF CLAIMANT



## INSTRUCTIONS FOR SUPPLEMENTAL REPORTING FORM – ORGANIZATIONAL CLEARANCE CERTIFICATE HOLDERS – NONPROFIT HOSPITAL ORGANIZATIONS

### FILING OF FORM

This form is to be filed as a supplemental schedule with BOE-278-OCC, *Verification for Continued Eligibility of Organizational Clearance Certificate-Welfare and Veterans' Organization Exemption*; which was mailed to your organization to verify and update our information. Form BOE-278-OCC must be completed and filed with the Board to maintain eligibility for your *Organizational Clearance Certificate*. All questions must be answered; leave no blanks. Use "no," "none," or "not applicable" where needed. Claim form BOE-278-OCC and this Supplemental Reporting Form must be sent to the County-Assessed Properties Division's Exemption Section at the address listed on page 1 of this form. If you have any questions, you may contact the Exemption Section at 916-445-3524.

#### 1. OPERATING REVENUES

State the organization's amount of operating revenues (exclusive of gifts, endowments and grants-in-aid) for each year.

#### 2. OPERATING EXPENSES

State the organization's amount of operating expenses for each year. (Expenses include depreciation based on cost of replacement and amortization of, and interest on indebtedness.)

#### 3. SURPLUS REVENUES

An organization must not be organized or operated for profit in order to continue to qualify for an Organizational Clearance Certificate and the welfare exemption. Hospitals are not deemed to be organized or operated for profit, if, their operating revenues (exclusive of gifts, endowments and grants-in-aid) did not exceed operating expenses by an amount equivalent to ten percent of those operating expenses during the immediately preceding fiscal year. (See Revenue and Taxation Code section 214, subdivision (a)(1).) However, surplus revenues may be used for specific purposes, such as debt retirement, expansion of plant and facilities or reserve for operating contingencies without disqualifying for the exemption.

State the amount of surplus revenues for each year by using the calculation in 3a.

#### 4. OPERATING AND NON OPERATING EXPENSES

State the organization's amount of operating revenues, operating expenses, non operating revenues and non operating expenses, and net operating income.

#### 5. FINANCIAL STATEMENTS AND FORM 990

In submitting a copy of certified financial statements (balance sheet and operating statement) of the organization, the complete financial details of the organization should be included. If the nature of any item of income or expense is not clear from the account name, further information indicating the nature of the account should be appended. Submit a copy of Form 990, and applicable schedules filed with the Internal Revenue Service for the last 4 years. Do not submit paper copies of statements or returns; submit an electronic copy in PDF format.

#### 6. USE FOR OF SURPLUS REVENUES

If the organization had surplus revenues, as calculated in 3, identify the amounts used for debt retirement, plant or facility expansion, or reserve for operating contingencies for each year.

- **Debt Retirement** - Funds required by external sources to be used to meet debt service charges and the retirement of indebtedness on plant assets.
- **Facility Expansion** - The addition of land and/or improvements to a coordinated group of fixed assets – land, buildings, machinery, and equipment constituting a plant.
- **Reserve for Operating Contingencies** - A segregation of retained earnings evidenced by the creation of a subordinate account to meet unforeseen financial needs due to emergencies and changing medical needs.

#### 7. PLANT OR FACILITY EXPANSION

Provide a description of plant or facility expansion projects; identifying the project location, scope and timeline for completion.

#### 8. PROPERTIES CLAIMED FOR EXEMPTION

Provide a listing of properties upon which your organization is claiming the welfare exemption; identifying the property location (physical address, city, county and Assessor's Parcel Number.)

**9. CHARITY CARE POLICY**

Indicate whether or not the organization has a charity care policy. If yes, provide a copy of the policy and specific information on the policy, including identification of the accounts (number and description) used to record charity care and the cost amounts for each year.

**10. MEDICAL CARE PROVIDED**

Indicate whether or not the organization's hospital provides medical care to Medicare, Medi-Cal or county indigent program recipients for each year. If yes, provide the amount of contractual adjustments in accordance with the Office of Statewide Health Planning and Development's Uniform System of accounts for hospitals; the amount received for such care; and cost of such care according to the organization's cost accounting system.

**11. DISCOUNTED PAYMENTS FOR MEDICAL CARE**

Indicate whether or not the organization's hospital provides medical care for which discounted payments were received from patients for care, excluding than Medicare, Medi-Cal or county indigent program recipients. If yes, identify the accounts (number and description) used to record discounted payment data; the amounts received for such care; and cost of such care according to the organization's cost accounting system.

**12. BAD DEBT**

Indicate whether or not the organization's hospital incurred bad debt expense for each year. If yes, provide the amount of bad debt in accordance with the Office of Statewide Health Planning and Development's Uniform System of accounts for hospitals.

**13. COLLECTION SERVICES**

Indicate whether or not the organization used a third-party collection services to collect revenue from unpaid medical services for each year. If yes, provide the number of delinquent accounts, debt amount and total amount collected. Additionally, attach a list of debt collection firms used and contract for such services. Identify the number of liens on delinquent accounts, the amount collected from liens, and the cost incurred for collection of such delinquent accounts.

- **Third party collection service** – includes, but not limited to, an affiliated or unaffiliated debt collection firm, attorney, or any other type of outside collection service used by the hospital to collect delinquent accounts for medical services, whether or not the account was assigned, transferred or sold to the collection service, and whether or not, the hospital entered into a contract for this service.

**14. JOINT VENTURES**

Indicate whether or not the organization invested in, contributed assets to, or participated in any joint venture or similar arrangement with a non-profit or for-profit entity during any of the specified fiscal years. If yes, provide the total number of joint ventures and attach a description identifying the terms and entities involved (including the name of the entity, the entities legal owner, type of business, the amount and source of funds/assets invested, and if unrelated business income was earned).

**15. ASSISTANCE TO NON-RELATED ENTITY**

Indicate whether or not the organization provided funds, grants or non-cash assistance to unrelated nonprofit or public health care facilities serving indigent patients; and provide the amount contributed according to the hospital's cost accounting system.

**16. AFFILIATED ENTITIES**

Provide an organization chart that indicates all legal entities related to and/or affiliated with your organization (the nonprofit organization receiving the welfare exemption from property taxation under Revenue and Taxation Code section 214). Your submission must identify the full names of the entities, their location (street address, city), and status (non-profit or for-profit).

**17. MULTI-SPECIALTY CLINICS**

Indicate whether or not the organization owned and operated one or more outpatient clinics (clinics providing psychiatric services to children and/or multispecialty clinics described in Health & Safety Code § 1206, subdivision(l)), which receive the welfare exemption from property taxation under Revenue and Taxation Code sections 214 for each year. If yes, provide the total number of outpatient clinics providing services and attach a list of clinics. The listing must include the clinic's full name, complete street address and type of clinic.

- **Outpatient Clinics** –There are two types of outpatient clinics, whether or not patients are admitted for an overnight stay or longer, are eligible for the welfare exemption under the hospital purpose of section 214, including a clinic that provides psychiatric services for emotionally disturbed children and a nonprofit multispecialty clinic. Health & Safety Code section 1206, subdivision (l) defines multispecialty clinic as a clinic operated by a nonprofit tax-exempt organization, which provides health care, health education, and conducts medical research through a group of 40 or more physicians and surgeons who are independent contractors representing not less than 10 board-certified specialties and not less than two-thirds of whom practice on a full-time basis at the clinic. The multispecialty clinic may consist of a single outpatient clinic or multiple clinics operated as a single unified integrated clinic in the aggregate. (Further information on outpatient clinics qualifying for the welfare exemption is available in Assessor's Handbook, Section 267, Welfare, Church, and Religious Exemptions, located on the Board's website at: <http://www.boe.ca.gov/proptaxes/pdf/ah267.pdf>)

**18. EXECUTIVE COMPENSATION**

Provide the total compensation for the three most highly-compensated executives of the hospital organization. Identify the amounts of each component for each executive as reported in the organizations IRS Form 990; (1) compensation, (2) contribution to employee benefit plans and deferred compensation, (3) expense accounts and other allowances.